STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 00 B. WING	03/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

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F 000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00168899. Complaint IN00168899- Substantiated. Federal/State deficiencies related to the allegations are cited at F314. Survey dates: March 19, 20, 23, 24, 25, & 26, 2015. Facility number: 013005 Provider number: 155816 AIM number: 201256400 Survey team: Beth Walsh, RN-TC Karina Gates, Generalist (March 24, 25, & 26, 2015) Tom Stauss, RN Angie Stallsworth, RN Census bed type: SNF:43 SNF/NF: 19 Residential: 15 Total: 77 Census payor type: Medicare: 31	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Medicaid: 19 Other: 12 Total: 62 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 2, 2014, by Cheryl Fielden, RN.			
F 280 SS=D Bldg. 00	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent			

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	practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, interview, and record review, the facility failed to update a resident's care plan regarding the resident's preference to remain in bed for 1 of 22 residents reviewed for care plans. (Resident #2) Findings include: Resident #2's record was reviewed on 3/23/15 at 1:49 p.m. The resident's diagnoses included, but were not limited to, Type 1 diabetes, hypertension, congestive heart failure, coronary artery disease, hyperlipidemia, neuropathy, stage IV kidney disease, and a history of stroke and heart attack. A 2/1/15 MDS (Minimum Data Set) assessment indicated Resident #2 had a BIMS (Brief Interview for Mental Status) score of 13 which indicated the resident did not have a severe cognitive impairment. On 3/23/15 at 2:35 p.m., during an observation, Resident #2 was lying in a bed in his room.	F 280	**F 280 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #2 care plan interventions were reviewed and updated related to the resident's preference to remain in bed frequently. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DHS or designee will review and update all care plan interventions related to the following: resident's preference to remain in bed. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Interdisciplinary Care Plan Team on the following guidelines: Interdisciplinary Team Care Plan **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents per unit will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1. Review of care plan to ensure	04/25/2015

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	On 3/24/15 at 10:27 a.m., during an observation, Resident #2 was lying in a bed in his room and a television was on nearby. On 3/25/15 at 9:19 a.m., during an interview, LPN #1 indicated Resident #2 "very rarely" gets out of bed according to his preference and he frequently refused staff attempts to assist him out of bed. She did not know if the resident's preference to remain in bed was in the resident's care plan. On 3/25/15 at 9:26 a.m., during an interview, CNA #2 indicated Resident #2 "might get out of bed once a month" and indicated it was the resident's preference to stay in bed. He indicated the resident frequently declined staff attempts to assist him to get out of bed. On 3/25/15 at 9:42 a.m., during an interview, the DHS (Director of Health Services) indicated Resident #2 had frequently refused to get out of bed since his admission to the facility on 12/2/14. She indicated staff would offer to assist the resident to get out of bed daily, but he frequently refused as he "liked to be in bed." On 3/26/15 at 8:58 a.m., during an interview, the DHS indicated Resident		interventions for resident's preference to remain in bed. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	#2's care plan was not updated with the resident's choice to stay in bed and refuse staff attempts to assist him out of bed. She indicated the facility should have updated the resident's care plan after the staff identified the resident's preference to remain in bed frequently. 3.1-35(d)(2)(B)			
F 282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to administer anticoagulation medication and insulin as ordered for 1 of 5 residents reviewed for unnecessary medication. (Resident #52) Findings include: 1. a) The clinical record for Resident #52 was reviewed on 3/26/15, at 9:30 a.m. The diagnoses for Resident #52 included, but were not limited to, right hip fracture and diabetes.	F 282	**F 282** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #52 MAR reviewed to ensure any anticoagulant medication and sliding scale insulin is administered/documented as ordered.	04/25/2015

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	The March, 2015 Physician's Orders indicated 30 mg of Lovenox (anticoagulation medication) to be given to Resident #52 subcutaneously (under the skin), by injection, daily after rising. The 3/12/15 Orthopedic Physician Note for Resident #52 indicated for the Lovenox to be continued for 1 more week. The 3/12/15 Physician Telephone Order indicated to discontinue the Lovenox on 3/19/15. The March, 2015 MAR (medication administration record) indicated Lovenox was not administered from 3/14/15 through 3/19/15, as ordered. An interview was conducted with the ADHS (Assistant Director of Health Services) on 3/26/15, at 10:55 a.m. She indicated she did not know what happened in regards to the Lovenox, but the physician would be informed Resident #52 was not given the Lovenox as ordered. An interview was conducted with LPN #7 on 3/26/15, at 12:51 p.m. She indicated she worked on 3/14/15, 3/15/15, and 3/16/15. She indicated she administered Resident #52's other		**Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DHS or designee will review the following: 1. All residents with ordered anticoagulant medication to ensure it is being administered/documented as ordered. 2. All residents with ordered sliding scale insulin to ensure the correct amount is administered / documented on the MAR according to the results of the blood sugar reading as ordered. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Licensed Nurses on the following guidelines: 1. Specific Medication Administration Procedures 2. Blood Sugar Monitoring **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents per unit will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1. Anticoagulant medication is	

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	morning medications, but didn't administer her Lovenox any of those days. b) The March, 2015 Physician's Orders for Resident #52 indicated Novolog (insulin) to be administered sliding scale for the following blood sugar readings: 131-150=1 Unit, 151-250=2 Units, 251-300=3 Units, 301-350=4 Units, 351-400=5 Units, and over 400=6 Units. The March, 2015 MAR for Resident #52 indicated the following blood sugar readings and Units of insulin given for those readings: 3/1/15 before lunch: 148, no insulin given 3/2/15 before breakfast: 138, no insulin given 3/3/15 before lunch: 80, 3 Units given 3/6/16 before lunch: 153, 3 Units given 3/12/15 before lunch: 104, 3 Units given 3/16/15 before lunch: 131- no insulin given 3/20/15 before dinner: 232, (Units section was blank) 3/21/15 before lunch: 140, 3 Units given An interview was conducted with the ADHS on 3/26/15, at 11:02 a.m., regarding the incorrect amounts of insulin given for the above blood sugar		being administered/documented as ordered 2. Sliding scale insulin is being administered / documented on the MAR according to the results of the blood sugar reading as ordered. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	readings. She indicated, "There's obviously a problem here." The Individual Care Plan for Resident #52 indicated, "Administer my insulin as ordered....My goal is to have no diabetic stress." The Medication Administration Policy was provided by the Clinical Support Clinician on 3/26/15, at 12:28 p.m. It indicated, "Medications are administered as prescribed in accordance with good nursing principles and practices...Medications are administered in accordance with written orders of the attending physician....The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off duty without first recording the administration of any medications." 3.1-35(g)(2)			
F 314 SS=D Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES			

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	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on interview and record review, the facility failed to timely address a resident's skin conditions, after recognition upon admission, for 1 of 3 residents reviewed for pressure ulcers. (Resident #D) Findings include: The clinical record for Resident #D was reviewed on 3/25/15, at 9:30 a.m. The diagnoses for Resident #D included, but were not limited to, stage 2 pressure ulcer left heel and stage 2 pressure ulcer right heel. The 10/24/15 Nursing Admission Assessment & Data Collection form indicated Resident #D had an intact blister on his left heel, measuring 2.8 cm X 3.4 cm. It described his right heel as "dark, red, smooshy". The Skin Plan of Care indicated on the form was to turn and reposition for comfort and with care; prevent skin from touching skin; elevate	F 314	**F 314 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #D was discharged from the campus. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: Review of all residents who currently have skin impairment to ensure the skin condition is re-assessed in a timely manner, a treatment and interventions are in place. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: General Wound and Skin Care **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents per unit will be	04/25/2015

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	heels off surface; provide pressure relieving device in chair and bed; and to assist with positioning in bed and chair. The tool indicated he did not have a stage 1 wound or greater. The 11/10/15 Pressure Ulcer Assessment form for Resident #D's left heel indicated the initial identification of the wound was on 11/10/15. It indicated it was a stage 2 and measured 2 cm x 2 cm x 0.1 cm. There was no Pressure Ulcer Assessment form for Resident #D's right heel. The 11/11/15 Wound Tracking form indicated Resident #D's left heel wound was a ruptured blister, stage 2, measured 1.5 cm x 1 cm x 0.1 cm, and had skin prep for treatment. This form indicated the right heel wound was a blister, stage 2, measured 1 cm x 1 cm x 0.1 cm, and had skin prep for treatment. There were no wound tracking forms for Resident #D's pressure ulcers in the clinical record prior to 11/11/15. An interview was conducted with the DHS (Director of Health Services) and the ADHS (Assistant Director of Health Services), who also served as the Facility Wound Nurse, on 3/25/15, at 12:38 p.m. The DHS indicated Resident #D's 10/24/15 Nursing Admission Assessment should have been reviewed the morning		conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review of residents with skin impairment to ensure the skin condition is re-assessed in a timely manner, a treatment and interventions are in place. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	of 10/25/15, at which point, a low air loss mattress would have been put in place for him. The DHS indicated the blister to his left heel, found on admission, was a stage 2 pressure ulcer. The Wound Nurse/ADHS indicated she was not told about the blister to Resident #D's left heel until 11/11/15, and had she known prior, would have put a treatment order in place and put Resident #D on her weekly wound rounds. The Wound Nurse/ADHS indicated a low air loss mattress was not put in place for Resident #D until 11/11/15. The Wound Nurse/ADHS indicated the skin prep to Resident #D's right heel was put in place effective 11/11/15, but had she known about his right heel skin impairment upon his 10/24/14 admission, would have started the skin prep sooner. An interview was conducted with the Clinical Support Clinician on 3/25/15, at 3:13 p.m. She indicated a skin assessment form should have been completed to track all pressure areas on Resident #D, after being identified on admission. The General Wound and Skin Care Guidelines policy was provided by the Clinical Support Clinician on 3/25/15, at 3:20 p.m. It indicated, "The following general wound and skin care guidelines			

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	should be followed for all residents with potential and/or actual impairment in skin integrity....20. Document type of wound, location, stage (if applicable), length, width, depth (in cms), base, drainage, periwound tissue, and treatment of the wound weekly using the wound/skin treatment flow sheet. 21. Notify wound care nurse/nurse supervisor for all new stage II-IV pressure ulcers or if you have any questions." This Federal tag relates to Complaint IN00168899. 3.1-40(a)(2)			
F 329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs			

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	receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the facility failed to ensure residents were assessed for the nature or intensity of their pain prior to administration, non-pharmacological interventions were tried prior to administration, and for the effectiveness of the medication after the administrations of PRN (as needed) pain medication for 2 of 5 residents reviewed for unnecessary medication and 1 of 3 residents reviewed for accidents. (Resident #'s E, 104, 6) Findings include: 1. The clinical record for Resident #E was reviewed on 3/24/15, at 9:30 a.m. The diagnoses for Resident #E included, but were not limited to, C1 cervical fracture. The 1/18/15 hospital records for Resident #E indicated, "Clinical Impression: 1. Compression fracture of C-spine 2. Traumatic hematoma of head 3. Multiple abrasions....Discharge: ...follow up care discussed with Arlington Place, Nurse (name of nurse), prescriptions for Norco (pain medication) given." The 1/18/15 Physician Telephone Order	F 329	**F 329** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #E has been discharged from the campus. Res #104 and #6 - review PRN tracking sheet to ensure documentation is in place that the residents are assessed for the nature or intensity of their pain prior to administration, non-pharmacological interventions were tried prior to administration, and for the effectiveness of the medication after the administration of a PRN pain medication. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DHS or designee will review the following: All residents with an order for PRN pain medication to ensure documentation is in place that they are assessed for the nature or intensity of their pain prior to administration, non-pharmacological interventions were tried prior to	04/25/2015

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	indicated one 5-325 mg tablet of hydrocodone (pain medication) to be given every 6 hours, as needed, for pain due to Resident #E's cervical fracture. The January, 2015 MAR (medication administration record) for Resident #E indicated he was given the PRN hydrocodone on the following dates and times: 1/20/15 at 8:30 a.m., 1/21/15 at 3:00 p.m., 1/22/15 at 9:00 p.m., 1/24/15 (no time documented), 1/28/15 at 8:00 p.m., and 1/30/15 (no time documented). There was no information in the clinical record to indicate Resident #E was assessed for the nature or intensity of his pain prior to administration, non-pharmacological interventions were tried prior to administration, or for the effectiveness of the medication after the administrations. An interview was conducted with the DHS (Director of Health Services on 3/24/15, at 12:37 p.m. She acknowledged a lack of verification in the clinical record for the assessment of Resident #E's pain prior to and after the above prn pain medication administrations. She indicated Resident #E's pain was "pretty bad" when he returned from the hospital on 1/18/15. 2. The clinical record for Resident #104 was reviewed on 3/23/15 at 1:45 p.m.		administration, and for the effectiveness of the medication after the administration of a PRN pain medication. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: 1). Administration of PRN Medications 2). PRN Medication Tracking Log **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits for 5 residents per unit will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review of residents with an order for / received PRN pain medication to ensure documentation is in place that they are assessed for the nature or intensity of their pain prior to administration, non-pharmacological interventions were tried prior to administration, and for the effectiveness of the medication after the administration of a PRN pain medication.	

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	155816	A. BUILDING 00 B. WING	03/26/2015

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	The diagnoses for Resident #104 included, but were not limited to, muscle weakness, chronic obstructive pulmonary disease, hypoxemia, and dyspnea. The December 2014 Physician's Orders indicated an order for Norco (narcotic pain reliever) 5/325 mg (milligrams) to be administered every 4 hours as needed (PRN). The December 2014 MAR (medication administration record) indicated Norco was given on the following days: 12/1/14 (time indecipherable), 12/2/14 (time indecipherable), 12/7/14 (11:00 a.m.), 12/8/14 (11:00 p.m.), 12/17/14 (10:30 [no a.m./p.m.]), 12/19/14 (10:00 p.m.), 12/22/14 (11:00 p.m.), 12/23/14 (10:00 p.m.), 12/26/14 (time indecipherable), 12/27/14 (time indecipherable), 12/28/14 (time indecipherable), 12/30/14 (time indecipherable), & 12/31/14 (time indecipherable) .. There was no information in the clinical record to indicate Resident #104 was assessed for the nature or intensity of her pain prior to administration, non-pharmacological interventions were tried prior to administration, or for the		The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	effectiveness of the medication after the administrations of PRN Norco. A Pain Management Care Plan, no date but was current at the time of review, indicated an intervention to monitor for the effectiveness of the pain medication. During an interview with the Director of Health Services (DHS), on 3/23/15 at 2:13 p.m., she indicated nursing staff was supposed to document the necessity for the PRN pain medication and the effectiveness of the PRN pain medication administered. On 3/24/15 at 12:30 p.m., the DHS indicated she was unable to locate documentation regarding the need for the above PRN pain medication and the effectiveness of the PRN pain medication administered. The DHS further indicated the purpose of documenting/tracking administration of PRN pain medication was to ensure the pain was being adequately controlled and to determine if there was a recurrent pain issue for a resident. 3. The clinical record for Resident #6 was reviewed on 3/24/15 at 1:45 p.m. The diagnoses for Resident #6 included, but were not limited to, diabetes mellitus, arthritis, depression, and Parkinson's			

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	disease. The February 2015 Physician's Orders indicated an order for Ultram (opioid pain reliever) 50 mg (milligrams) to be administered as needed (PRN) for pain. The February 2015 MAR (medication administration record) indicated PRN Ultram was given on the following days: 2/4/15 (2:00 p.m.), 2/7/15 (3:00 a.m.), 2/8/15 (1:00 p.m.), & 2/28/15 (4:00 p.m.). There was no information in the clinical record to indicate Resident #6 was assessed for the nature or intensity of her pain prior to administration, non-pharmacological interventions were tried prior to administration, or for the effectiveness of the medication after the administrations of PRN Ultram. During an interview with the Director of Health Services (DHS), on 3/25/15 at 3:20 p.m., the DHS indicated she was unable to locate documentation regarding the need for the above PRN pain medication and the effectiveness of the PRN pain medication administered. A policy titled, Administration of PRN Medication Guideline, no date, was			

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	received from the DHS, on 3/25/15 at 9:10 a.m. The policy indicated, "...3. Documentation should reflect the reason for administering the PRN medication. a. i.e.: c/o [complaint of] of [sic] headache,...wringing hands, c/o of [sic] hip pain....5. Follow up should be noted to ensure the effectiveness and/or assess for adverse side effects." 3.1-48(a)(6)			
R 000 Bldg. 00	These state deficiencies are cited in accordance with 410 IAC 16.2-5.	R 000		
R 217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires			

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	change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure a Resident had signed a Service Plan. This affected 1 of 5 residents reviewed for service plans (Resident #8). Findings include: The clinical record for Resident #8 was reviewed on 3/26/15 at 11:45 a.m. The diagnoses for Resident #8 included, but were not limited to, congestive heart failure, diabetes mellitus, and chronic obstructive pulmonary disease. The Service Plans for Resident #8, dated 1/10/15 and 2/8/15, did not indicate a signature for Resident #8. During an interview with the Director of Health Services (DHS), on 3/26/15 at 12:15 p.m., she indicated Service Plans	R 217	**R 217** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #8 has a signed service plan in place. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DHS or designee will review all service plans to ensure they are signed by the resident and/or representative. **Measures put in place and**	04/25/2015

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	should have a Resident or POA (Power of Attorney/Responsible Party) signature on them. On 3/26/15 at 1:50 p.m., the Clinical Support Clinician (CSC) indicated the facility was not able to locate a signed Service Plan for Resident #8. A policy titled, Guidelines for Evaluation and Service Plan, dated 10/12, was received from the CSC on 3/26/15 at 2:15 p.m. The policy indicated, "...4. The resident and/or responsible party should also review and sign the form...."		**systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: Evaluation and Service Plan. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review service plans to ensure they are signed by the resident and/or representative. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	
R 240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.			

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	Based on interview and record review, the facility failed to follow a Physician's Order/individual need for weekly weights for 1 of 5 residents reviewed for Physician's Orders (Resident #8). Findings include: The clinical record for Resident #8 was reviewed on 3/26/15 at 11:45 a.m. The diagnoses for Resident #8 included, but were not limited to, congestive heart failure, diabetes mellitus, and chronic obstructive pulmonary disease. The February 2015 Physician's Order indicated an order for weekly weights and to notify the Physician of a 5 pound gain in a week. The order was initiated on 11/1/14. The following weights were not located in the clinical record: 2/5/15, 2/12/15, & 2/19/15 Resident #8's Service Plans, dated 1/10/15 and 2/8/15, indicated to weigh per orders. During an interview with the Clinical Support Clinician, on 3/26/15 at 1:50 p.m., she indicated the facility was unable	R 240	**R 240 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #8 - review to ensure weights are obtained as ordered. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DHS or designee will review all residents with weight monitoring to ensure they are obtained as ordered. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Licensed Nurses on the following guideline: Evaluation and Service Plan **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review residents with weight monitoring to ensure they are obtained as ordered. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further	04/25/2015

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	to locate the above weights for Resident #8. A policy titled, Guidelines for Evaluation and Service Plan, dated 10/12, was received from CSC on 3/26/15 at 2:15 p.m. The policy indicated, "...6. A service plan shall be identified and implemented in response to the resident's evaluation...."		recommendation.	
R 298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.			

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	Based on interview and record review, the facility failed to ensure a pharmacist reviewed a Resident's drug regimen at least once every sixty days. This had the potential to affect 1 of 5 residents reviewed for pharmacist review (Resident #8). Findings include: The clinical record for Resident #8 was reviewed on 3/26/15 at 11:45 a.m. The diagnoses for Resident #8 included, but were not limited to, congestive heart failure, diabetes mellitus, and chronic obstructive pulmonary disease. A Pharmacist Review for Resident #8 was not located in the clinical record. During an interview with the Clinical Support Clinician (CSC), on 3/26/15 at 2:50 p.m., she indicated the facility was able to locate a Pharmacist Review for the months of September 2014 and January 2015. A Pharmacist Review was not located for the month of November 2014. A policy titled, Pharmacy Guidelines, dated 10/12, was received from the CSC on 3/26/15 at 2:55 p.m. The policy indicated, "...5. The campus pharmacy consultant shall review the resident's	R 298	**R 298 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #8 - pharmacist has reviewed the drug regimen. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DHS or designee will review all residents to ensure the pharmacist has reviewed the drug regimen in the past 60 days. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Licensed Nurses on the following guideline: Pharmacy Guidelines **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review residents to ensure the pharmacist has reviewed the drug regimen in the past 60 days. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further	04/25/2015

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	medication regime every 60 days...."		recommendation.	
R 410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, the facility failed to ensure a tuberculin skin test was completed on/or prior to admission for 1 of 7 resident's records reviewed for tuberculin testing. (Resident #17) Findings include:	R 410	**R 410** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #17 has a	04/25/2015

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	The clinical record for Resident #17 was reviewed on 3/26/15 at 12:00 p.m. Resident #17 was admitted on 11/20/14. The diagnoses for Resident #17 included, but were not limited to, breast cancer, dementia, cerebrovascular accident with left side hemiparesis. A document titled, "Immunization Record" indicated Resident #17 received a tuberculosis skin test on 2/11/15, and it was read on 2/13/15. On 2/19/15, Resident #17 received another tuberculosis skin test, and it was read on 2/22/15. An interview was conducted with the Clinical Support Clinician on 3/26/15 at 1:45 p.m. She indicated she could not provide information in which Resident #17 was given a first or second step tuberculosis skin test on or prior to admission to the facility. A policy titled, "Assisted Living Guidelines Chest X-ray and Mantoux Testing" was provided on 3/27/15 at 2:15 p.m. by the Clinical Support. It indicated the following: "Purpose: to ensure residents are free of tuberculosis prior to admission. Procedure: 1. Residents should have a Mantoux PPD (purified protein derivative) test:.. b. Indiana - within 3 months of admission if proof of		current tuberculin skin test documented. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DHS or designee review all residents to ensure a current tuberculin skin test is documented. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: Assisted Living Guideline Chest X-Ray and Mantoux Testing **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 new admission residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review new admission residents to ensure a tuberculin skin test was completed and documented on/or prior to admission.	

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	previous testing or upon admission...		The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	